Health Care for the Homeless

Comprehensive Services to Meet Complex Needs
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Serious personal health problems and flaws in health care systems are major contributors to contemporary homelessness. Some health problems — drug addiction, serious mental illness, and physical disabilities — are distressingly obvious, particularly in persons living in public spaces. Other problems are less visible but equally insidious, undermining capacity to maintain stable housing and function independently. In far too many cases, a fragmented health care delivery system has not responded adequately to the multiple needs of homeless persons, who are indigent and typically uninsured.

Soon after the dramatic increase of homelessness in the 1980s, health care professionals, shelter providers, advocates, government agencies and homeless people themselves recognized that a concerted health care response was required. A successful, 4-year Health Care for the Homeless demonstration program, operated in 19 cities with financial support from the Robert Wood Johnson Foundation and the Pew Charitable Trust, was replicated in the Stewart B. McKinney Homeless Assistance Act of 1987. The Health Resources and Services Administration, which administers the federal Health Care for the Homeless (HCH) Program authorized by this legislation, began funding homeless health projects in 1988.

By 2001, HCH projects existed in every state, the District of Columbia, and Puerto Rico. HCH projects are created and operated by the communities they serve, are widely heralded as a smart and effective approach to homelessness, and continue to emerge in additional communities as the Consolidated Health Center Program of which they are part continues to expand.

This brochure briefly describes the connection between homelessness and poor health, and explains how HCH projects are responding. Health and social service providers who are working to end homelessness in their own communities, those who seek to improve the delivery of health care in the United States, and those who are interested in learning about one of the major social problems of our time will find in Health Care for the Homeless a rich history, a wealth of knowledge, and colleagues dedicated to ending homelessness in our country.

THE EXTENT OF HOMELESSNESS
Number of Homeless Persons Annually: 3.5 million
Number of Homeless Persons Nightly: 842,000

—National Law Center on Homelessness & Poverty

Homelessness and Poor Health
Research over the last 20 years has demonstrated that homelessness and poor health are strongly correlated in three ways:

• Health Problems Cause Homelessness Half of all personal bankruptcies in the United States result from health problems, it is a short downhill slide from bankruptcy to eviction to homelessness. Moreover, some health problems that are more prevalent among homeless than housed people — including infectious diseases, substance use disorders, and mental illnesses — are known to undermine the family and social supports that provide a bulwark against homelessness for many vulnerable people.

• Homelessness Causes Health Problems People without homes are mercilessly exposed to the elements, to violence, to communicable diseases and parasitic infestations. Circulatory, dermatological, and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Homeless people experience illnesses at three to six times the rates experienced by housed people.

• Homelessness Complicates Efforts to Treat Health Problems The health care delivery system is not well attuned to the realities of living without stable housing. Health care facilities often are located far from where homeless people stay, public transportation systems are insufficient or nonexistent in many places, and most homeless people don’t have cars. Clinic appointment systems are not easily negotiated by people without telephones, for whom other survival needs (finding food and shelter) take priority. Standard treatment plans often require resources not available to homeless persons, such as places to obtain bedrest, refrigeration for medications, proper nutrition or clean bandages.

These three correlations, noted by the Institute of Medicine nearly two decades ago, still obtain today. The mainstream health care system often is not prepared to contend with the psychosocial challenges and multiple co-morbidities commonly experienced by homeless people, and is unwelcoming toward those with behavioral health issues who may appear unclean or threatening, cannot pay for services, and typically lack health insurance. Consequently, many individuals who are homeless have had bad prior experiences with the health care delivery system and avoid mainstream providers.
In communities nationwide, projects providing primary care to homeless people seek to disrupt the terrible nexus between poor health and homelessness. As of July 1, 2008, 202 HCH grantees of the Health Resources and Services Administration (HRSA) were providing health and social services to more than 740,000 clients per year. These projects typically operate as part of Community and Migrant Health Centers, hospitals, or Departments of Public Health, or as freestanding agencies. Most combine HRSA funding with other revenue and grants to provide a broad range of services.

At a minimum, each project provides a prescribed set of required services, including primary health care and substance abuse services, emergency care and referrals, outreach and assistance in qualifying for entitlement programs and housing. Many HCH projects go well beyond these basic services, offering dental care, mental health treatment, medical respite services, supportive housing, and other services needed to resolve their clients’ homelessness.

To engage homeless persons and to provide effective care, HCH projects utilize a number of approaches that accommodate the realities of homelessness. These include:

- **Outreach** HCH physicians, nurses, social workers and others skilled at making connections with homeless people (often including persons who have experienced homelessness themselves) seek out and bring care to homeless people wherever they are — in encampments, under bridges, on the streets, in jails, at soup kitchens and other service sites.

- **Service locations** HCH clinics are located in or near shelters and other places where homeless people congregate.

- **Service hours** Many HCH projects operate during extended hours to accommodate the schedules of clients who work or must be elsewhere at certain times to secure food or shelter.

- **Transportation** HCH projects frequently provide transportation to and from clinics, specialty providers, social security or food stamp offices, and shelters.

- **Elimination of financial barriers** HCH projects assure that inability to pay even a small fee does not impede access to health services.

- **Sensitivity** HCH staff endeavor to understand the unique circumstances and stresses associated with homelessness. They understand that the process of engaging individuals who are homeless often involves overcoming significant fear and suspicion, and that a patient, nonjudgmental, persistent approach is often required.

- **Comprehensive services** HCH providers understand that health care and other basic needs are interrelated and strive to address each client’s needs holistically through the use of multidisciplinary clinical teams. Integration of primary care with the treatment of mental health and substance use disorders is a hallmark of HCH practice, and efforts to secure housing, entitlements, and jobs are intrinsic to this approach.

- **Case management** Coordination of a wide range of on-site and referral resources receives particular attention in the HCH approach to care.

THE HOUSING SHORTAGE

9 million low-income renter households nationwide pay more than half of their income for housing.

In no community in the U.S. today can someone who gets a fulltime job at the minimum wage reasonably expect to find a modest rental unit he or she can afford.

—National Low Income Housing Coalition
Clinical adaptations
To promote favorable clinical outcomes, HCH providers have developed techniques such as prescribing simple medical regimens with few side effects, or screening for common problems during the first encounter with a client.

Advocacy
HCH staff engage in advocacy to secure client services, to protect clients’ rights, to affect the local service delivery systems so that it better meets the needs of their clients, and to change policies that cause, exacerbate, or create obstacles to resolving homelessness.

Client involvement
HCH projects are careful to involve their clients in developing realistic treatment plans, in the governance of their agencies, in evaluating the efficacy of homeless services, and in advocating for service improvements and policy change.

The Health Care for the Homeless Program employs a model of care that is appropriate for everyone, but is particularly well adapted to the circumstances of those most in need. By creating numerous new service delivery sites and modalities, the HCH Program has contributed importantly to the development of the health care infrastructure in the United States. In that respect, HCH is far more than a safety net. Yet for those whose personal circumstances have reduced them to homelessness and for whom all other systems have failed, HCH remains the final safety net.

The quality of care available through Health Care for the Homeless improves the health and well-being of displaced people and models for all service providers a high standard of care.